ND RYAN WHITE PROGRAM PART B ENROLLMENT APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 54191 (04-2015)

The following information is requested to determine if you qualify for the North Dakota Ryan White Program Part B. The law does not require that you provide the information. However, without this information, we may be unable to determine your eligibility for assistance, or help you with appropriate referrals.

It is against the law for you to provide information that is not true. If you do, you may be charged with a crime.

All the information you provide is private and confidential. Only those people who need the information to do their jobs will see your information. These people are the North Dakota Ryan White Program Part B staff, program auditors, private health insurance plans, your medical care providers, the county financial worker, your case manager, and any advocate you may list on this application. We will ask your permission for anyone else to see the information you give us.

Items you will need to provide:

☐ **Identity/Age**: Bring records that prove the identity and age of household member applying for assistance (birth certificate, driver's license, etc.).

☐ **Verification of Diagnosis** (if self-referred or referred by physician).

☐ **Expenses**: Bring current records for the following expenses to help us determine services for which you may be eligible:

- Medical Expenses
- Health insurance premium statement
- Utility/shelter payments:

☐ Rent/mortgage ☐ Heating/cooling costs
☐ Other utility bills ☐ Telephone bill

☐ **Income**: Bring records to show your gross/net income (most recent tax form, wage stubs, SSDI, SSI, etc.).

☐ **Health insurance**: Bring explanation of benefits and the insurance card. If uninsured bring a copy of the shared responsibility exemption.

☐ **Medicaid/Medicare**: Bring a denial or acceptance letter if your income is under 138 percent of the Federal Poverty Level (FPL).

☐ **Residence**: Bring records to show where you live (rent receipts, utility bills, etc.). You must be able to produce a state ID within 60 days of applying.

When you fill out this application:

- Answer all questions to the best of your knowledge.
- Sign and date where indicated.
- Return this form to:

Ryan White Program Part B
North Dakota Department of Health
2635 East Main Avenue
Bismarck, N.D. 58506-5520
Fax: (701) 328-0355

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ND Ryan White Case Management Site	ND Ryan White Client Number

Personal Information

Name of Applicant			Social Security Number		
Street Address			City	State	Zip Code
Mailing Address (if different)			City	State	Zip Code
Home Telephone Number		Cell Phone Number	Email Address		
Date of Birth	Gender	Race ☐White ☐Black/African American ☐Asian ☐American Indian ☐Pacific Islander			Hispanic or Latino: ☐Yes ☐No
Physician Name		Clinic	Physician's Telephone Number		
Pharmacy			Pharmacy's Telephone Number		
Name of Emergency Contact			Emergency Contact's Telephone Number		

Assistance Requested

☐ Case Management (all clients eligible) ☐ AIDS Drug Assistance Program (ADAP)
☐ Health Care (medical, oral) Payment Assistance ☐ Support Services (transportation, housing assistance, etc.)

Citizenship Status*

☐ Citizen ☐ National ☐ Green Card ☐ Undocumented

*N.D. Ryan White Program asks for information regarding citizenship status to best determine which health care program you qualify for. Information collected in this application will not be shared with any other program or agency for the purpose of determining citizenship.

Employment Status

☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Disabled ☐ Retired

Occupation	Employer

Veteran Status

☐Veteran ☐ Disabled veteran ☐ Non-veteran

Tobacco

1. Are you a tobacco user? ☐ Yes ☐ No ☐ Former User
2. Are you interested in quitting at this time? ☐ Yes ☐ No
3. Are you exposed to second hand smoke? ☐ Yes ☐ No
4. Referral offered? ☐ Yes ☐ No

Medical Coverage (please provide copies of insurance cards and benefit statements)

☐ No Insurance*

☐ Medicaid Expansion Policy number: _____
☐ Medicaid (Traditional) Policy number: _____ Recipient Liability: $_____

☐ Private – Individual Policy name and number: _____
Is this a Marketplace plan? ☐Yes ☐No

☐ Private – Employer Policy name and number: _____

☐ Medicare Part A/B
☐ Medicare Part D Part D policy name and number: _____

☐ VA, Other Military ☐ IHS ☐ Other (specify): _____

*If not insured please provide denial letters, shared responsibility exemption (obtained from the Marketplace or IRS), or sign Request to Decline Health Insurance Coverage.

Household Characteristics

Household/Family Size:

Household Type (Check one)	Housing Type (Check one)
☐ Single ☐ Partner ☐ Married ☐ Married with children ☐ Other (please specify):_____	☐ Stable/Permanent ☐ Unstable (homeless: shelter, vehicle, transitional housing, streets) ☐ Institution ☐ Temporary

Describe current living arrangement (stability, safety, affordability):

_____

_____

Where you live, do you: ☐ Rent ☐ Own What do you pay each month to live there?

Household Gross Income*

*If the applicant lists no income, the applicant must sign the program income verification form and explain how daily living expenses are met.

Is any household member, including applicant, working? ☐Yes ☐No

If yes, list information about full-time, part-time, seasonal or temporary employment for all household members 18 years of age and older related to the client by blood, marriage or adoption.

Name	Relationship	Birth Date	Type of Income	Monthly Gross Income
	Self			
			Household Monthly Gross Income	

Annual Household Gross Income	Household FPL (refer to table on page 6)

Your Monthly Expenses

Do you receive help for monthly housing or other expenses? If yes, please specify using the worksheet below.	☐Yes ☐No

Monthly Income	
Source	Amount
Salary, wages*	$
Spouse's Salary	$
Short-term Disability	$
Long-term Disability	$
SSI	$
SSDI	$
VA Pension	$
Child Support	$
Food Stamps	$
General Assistance	$
Savings/Investments**	$
Rental Income	$
Unemployment	$
Retirement Benefits**	$
Family Support	$
Other	$
Total	$

Monthly Expenses	
Source	Amount
Rent/Mortgage (circle one)	$
Telephone	$
Utilities	$
Car Payment	$
Insurance	$
Food	$
Day Care	$
Child Support	$
Alimony	$
Medical Expenses	$
Pharmacy/Drugs	$
Credit Card(s)	$
Other	$
	$
	$
	$
Total	$

*If you receive intermittent income from other sources, please list separately and indicate source and frequency (example: part-time work, approximately two months duration).

** Report only if you **receive income** from savings/investments or retirement benefits.

CERTIFICATION

I hereby certify that the representation of my income, insurance and other financial assistance is a true and accurate statement and that eligibility requirements as listed above have been met and documented. I also certify that any increases in income, insurance or other financial assistance will immediately be reported to my case manager. I understand reenrollment on an annual basis is required. I understand I must complete the reenrollment application and re-certification annually, and **if I have not re-enrolled by May 31 and re-certified by November 31, I will become ineligible to receive reimbursement for medical expenses through the ND Ryan White Program.**

I have received a copy of my responsibilities as a North Dakota Ryan White client and I agree to all terms.
☐Yes ☐No

Client/Guardian Signature _____ Date _____

Case Manager Signature _____ Date _____

Service Needs Assessment

Client's Name	Date

The following checklist will assist the ND Ryan White Program Part B to learn of any areas of concern that you may have so that we might best help you, either through our program or by referring you to other community resources.

Please check all items below that are concerns to you.

Income Management

- ☐ Housing, please specify _____
  _____
- ☐ Utilities
- ☐ Food
- ☐ Clothing
- ☐ Paying bills/money management
- ☐ Weatherization
- ☐ Housing and safety maintenance
- ☐ Income tax assistance
- ☐ Other (please specify) _____
  _____
  _____
  _____

Employment

- ☐ Finding/keeping a job
- ☐ Interviewing for a job
- ☐ Resume preparation
- ☐ Skills assessment
- ☐ Child care
- ☐ Transportation
- ☐ Other (please specify) _____

Education

- ☐ Enrolling for school (college)
- ☐ Training programs
- ☐ Adult Education: GED or refresher
- ☐ Children's education issues
- ☐ Other (please specify)_____

Health Care

- ☐ Medical
  - ☐ Eye
  - ☐ Hearing
  - ☐ Dental
  - ☐ Prescriptions
  - ☐ Diabetic Supplies
- ☐ Mental Health Issues
- ☐ Abuse Concerns
  - ☐ Alcohol/Drug
  - ☐ Tobacco
  - ☐ Physical
  - ☐ Emotional
- ☐ Other (please specify) _____

Personal Needs

- ☐ Parenting issues
- ☐ Support system
- ☐ Decision-making/problem-solving
- ☐ Counseling
- ☐ Legal issues
- ☐ Anger/conflict management
- ☐ Communication skills
- ☐ Significant issues (spouse, partner, etc.)
- ☐ Other (please specify) _____
  _____
  _____
  _____

To be filled out by case manager

Client was counseled regarding:

☐ HIV transmission risk ☐ Mental Health Issues ☐ Substance Abuse

ND Ryan White Program Part B Direct Client Contact

☐ I am interested in participating on a ND Ryan White Advisory Board as a consumer-advisor about issues related to my status and care. By marking this box, I authorize ND Ryan White Program staff to contact me directly.

☐ By marking this box, I authorize the ND Ryan White Program staff to mail information directly to me.

ND Ryan White Program Part B Certificate of Eligibility

The client's and case manager's signatures below certify that the following eligibility criteria for ND Ryan White Program reimbursement have been met:

- Confirmation of HIV Status. (Verified by referral from North Dakota Department of Health, or HIV diagnosis documented by physician – name of physician and date of documentation).
- North Dakota Proof of Residency provided (i.e., rent receipts, utility or phone bills) and within 60 days a state issued ID.
- Income Eligibility Criteria Met. Annual income limitations: less than, or equal to, 400 percent of the Federal Poverty Level (FPL).

2015 HHS Poverty Guidelines

Size of Family Unit	100 Percent of Poverty	138 Percent of Poverty	400 Percent of Poverty
1	$11,770	$16,242	$47,080
2	15,930	$21,983	$63,720
3	20,090	$27,724	$80,360
4	24,250	$33,465	$97,000

- Application for Medicaid/Medicare or other programs have been completed (if applicable). (If the applications have been denied, the denial letters must be on file with the case manager.)
- A copy of most recent income tax return (or a signed income verification form indicating no return was filed) is attached to this application.
- A copy of all insurance policies (front and back) and a copy of policy benefits.
- If uninsured a copy of shared responsibility exemption (obtained from Marketplace or IRS) **or** completed Request to Decline Health Coverage form.
- All other payment options are described on the ND Ryan White Program Part B Enrollment form.
- Release of Information form, SFN _____ signed.

Client/Guardian Signature _____ Date _____

Case Manager Signature _____ Date _____

ND Ryan White Program Part B Client's Rights and Responsibilities

As a participant in the ND Ryan White Program Part B, you have the right to:

- Be treated with respect, dignity, consideration, and compassion.
- Receive case management services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and/or mental ability.
- Participate in creating a plan for case management services.
- Be informed about services and options available to you.
- Reach an agreement with your case manager about the frequency of contact you will have, either in person or over the telephone.
- Have your medical records and case management records be treated confidentially.
- Have information released only in the following circumstances:
    - When you sign a written release of information.
    - When there is a medical emergency.
    - When a clear and immediate danger to you or others exists.
    - When there is possible child or elder abuse.
    - When ordered by a court of law.
- File a grievance about services you are receiving or denial of services.
- Not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

As a participant in the North Dakota Ryan White Program Part B, you have the responsibility to:

- Treat other clients and staff of this agency with respect and courtesy.
- Protect the confidentiality of other clients you may encounter at this agency.
- Not subject case managers, staff, or other clients to physical, sexual, verbal and/or emotional abuse or threats.
- Participate as much as you are able in creating a plan for case management.
- Let your case manager know any concerns you have about your case management plan or changes in your needs.
- Make and keep appointments to the best of your ability, or if possible to phone to cancel or change an appointment time.
- Stay in communication with your case manager by informing him/her of changes in your address or phone number, income, and responding to the case manager's calls or letters to the best of your ability.
- Provide your case manager any requests for payment of bills within 30 days of the statement date. Bills given to case managers after 30 days will not be covered.
- Apply for all programs your case manager asks of you to ensure ND Ryan White Program Part B is the "payer of last resort."
- File taxes and provide your case manager with the tax returns.
- Stay in care by visiting your doctor regularly and take prescribed medication to ensure your health and well-being.
- Annually re-certify your eligibility and enrollment in the ND Ryan White Program Part B. **Failure to re-enroll by May 31 or re-certify by November 31 will jeopardize continued assistance with health care and medication expenses.**

I understand the above information, and I have received a copy for my records.

Client/Guardian Signature _____ Date _____

Case Manager Signature _____ Date _____